

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4063AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/30/2010
NAME OF PROVIDER OR SUPPLIER ANGELS HOUSE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5496 TAMARUS STREET LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 3/30/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for nine Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was nine. Five employee files were reviewed.</p> <p>The facility received the grade of A.</p>	Y 000		
Y 103 SS=F	<p>449.200(1)(d) Personnel File - NAC 441A / Tuberculosis</p> <p>NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee.</p> <p>This Regulation is not met as evidenced by: Based on record review on 3/30/10, the facility failed to ensure 3 of 5 employees complied with NAC 441A.375 regarding tuberculosis (TB)</p>	Y 103		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 103	Continued From page 1 testing for the protection of all residents (Employee #2, #4 and #5). This was a repeat deficiency from the 11/4/09 State Licensure survey. Severity: 2 Scope: 3	Y 103			
Y 105 SS=F	449.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: Based on record review on 3/30/10, the facility failed to ensure 4 of 5 caregivers met background check requirements (Employee #1, #2, #4 and #5). This was a repeat deficiency from the 11/4/10 State Licensure survey. Severity: 2 Scope: 3	Y 105			

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